DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Newark Manor Nursing Home

DATE SURVEY COMPLETED: March 13, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from March 10, 2026, through March 13, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census on the first day of survey was fifty-eight (57). The survey sample totaled fourteen (14) residents. **Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement was not met as evidenced by: Cross Refer to the CMS 2567 – L survey completed March 13, 2026: F644.	Cross reference plan of correction for CMS 2567 for Annual, Complaint & Emergency Preparedness Survey ending 3/13/26, F641. A. Resident 6 continues to reside at the facility and was not impacted. The Level II PASRR was corrected for R6 on 3/12/26 to capture the reflected diagnoses of psychotic disorders, anxiety and behavioral symptoms in the residents' assessment, care planning and transitions of care. B. All residents admitted with a new diagnosis or possible serious mental disorder, intellectual disability or related condition for level II resident review upon a significant change were audited and reviewed by the Social Worker Director on 3/12/26 for status assessment of psychotic disorders, anxiety, and behavioral symptoms to ensure the PASRR evaluation report was captured in the resident's assessment, care planning, and transitions of care. No other residents were impacted. C. Root cause was the facility's failure to coordinate with the PASRR program under	4/24/2026

Provider's Signature _____ Title LNHA Date 3/24/2026

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		Medicaid and refer the resident for an assessment with an updated PASRR evaluation that includes a new diagnosis of anxiety, psychotic disorders and behavior symptoms after admission to the facility. The Social Worker Director, MDS Coordinator, and ADON completed education on 3/24/26 by the Director of Nursing regarding PASRR Level I and II requirements and Significant Change Triggers to identify, refer, and coordinate care for residents who may require a Level II PASRR evaluation. The facility has incorporated PASRR education into the new employee orientation for the Social Worker Director and MDS Coordinator. This education includes detailed instruction on PASRR Level I and Level II requirements, identification of significant change triggers (including new psychiatric diagnoses, behavioral symptoms, and related conditions), and the process for timely referral to the State PASRR authority. Education also includes coordinating care to ensure PASRR recommendations integrate into the resident's assessment, care planning, and transitions of care. This education is provided by the Director of Nursing, a licensed Registered Nurse (RN), provides this education and oversees clinical compliance and regulatory adherence. The	

Provider's Signature _____ Title _____ Date _____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A020	A. BUILDING B. WING	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWARK MANOR NURSING HOME	254 WEST MAIN STREET , NEWARK, Delaware, 19711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from March 10, 2026 through March 13, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		04/24/2026
F0000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from March 10, 2026, through March 13, 2026. The deficiencies contained in this report are based on observations, interviews, review of the residents' clinical records and review of other facility documents as indicated. The facility census on the first day of the survey was 58. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; DO – Doctor of Osteopathy; DON - Director of Nursing; MDS (Minimum Data Set) - federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; NHA - Nursing Home Administrator; NP – Nurse Practitioner; PASSR (Preadmission Screening and Resident Review) - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; Psych - Psychiatry;	F0000		04/24/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

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F0000	Continued from page 1 RN - Registered Nurse; SW - Social Worker.	F0000		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R6) out of four residents reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to coordinate with the PASRR program under Medicaid and refer the resident for an assessment. Findings include: Review of R6's clinical records revealed: 12/9/24 – A PASRR Level 1 Screen was completed prior to R6's admission to the facility. The PASSR Level 1 documented that "No mental health diagnosis is known or suspected." 2/4/25 – R6 was admitted to the facility with diagnoses including but not limited to unspecified dementia, unspecified severity, without behavioral disturbance and major depressive disorder. 2/17/25 – R6's Admission Minimum Data Set (MDS) assessment documented that R 6 had no serious mental illness and/or intellectual disability.	F0644	A. Resident 6 continues to reside at the facility and was not impacted. The Level II PASRR was corrected for R6 on 3/12/26 to capture the reflected diagnoses of psychotic disorders, anxiety and behavioral symptoms in the residents' assessment, care planning and transitions of care. B. All residents admitted with a new diagnosis or possible serious mental disorder, intellectual disability or related condition for level II resident review upon a significant change were audited and reviewed by the Social Worker Director on 3/12/26 for status assessment of psychotic disorders, anxiety, and behavioral symptoms to ensure the PASRR evaluation report was captured in the resident's assessment, care planning, and transitions of care. No other residents were impacted. C. Root cause was the facility's failure to coordinate with the PASRR program under Medicaid and refer the resident for an assessment.with an updated PASRR evaluation that includes a new diagnosis of anxiety, psychotic disorders and behavior symptoms after admission to the facility. The Social Worker Director, MDS Coordinator, and ADON completed education on 3/24/26 by the Director of NUrsing regarding PASRR Level I and II requirements and Significant Change Triggers to identify, refer, and coordinate care for residents who may require a Level II PASRR evaluation. The facility has incorporated PASRR education into the new employee orientation for the Social Worker Director and MDS Coordinator. This education includes detailed instruction on PASRR Level I and Level II requirements, identification of significant change triggers (including new psychiatric diagnoses, behavioral symptoms, and related conditions), and the process for timely referral to the State PASRR authority. Education also includes coordinating care to ensure PASRR recommendations integrate into the resident's assessment, care planning, and transitions of care. This education is provided by the Director of Nursing, a licensed Registered Nurse (RN), provides this education and oversees clinical compliance and regulatory adherence. The Director of Nursing is trained in PASRR regulatory requirements and ensures	04/24/2026

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F0644 SS = D	Continued from page 2 5/20/25 – R6's Quarterly MDS assessment documented that R6 's active diagnoses Non-Alzheimer's Dementia and Depression. 6/23/25 1:21PM – A nurse progress note documented "Resident became physically aggressive towards staff when attempting to provide AM care." 6/23/25 – R6 had the following new physician orders: 1. Rexulti Tablet 1 milligram, Give 1 tablet by mouth at bedtime for 14 days for depression. 2. Ativan Tablet 0.5 milligram, Give 1 tablet by mouth every six hours as needed for anxiety for 14 Days. 6/23/25 1:00 AM – An encounter note by P1(NP) documented "Plan: 1. Dementia with behaviors, continue to monitor moods and behaviors, will initiate Rexulti and consult psych for evaluation. 2. Depression with insomnia, will decrease trazodone from 100 mg to 50 mg, continue to monitor moods and behaviors encourage good sleep habits and follow-up with psych as needed…" 6/24/25 1:00 AM- An encounter note by P2(DO) documented "Assessment… Psychosis… Associated with behavioral abnormalities Appears to be secondary to underlying neurocognitive disorder (sic) Continue medical therapy with Rexulti, trazodone and as needed lorazepam (sic) Attempt gradual dose reduction as tolerated Psychiatry evaluation and follow-up as indicated…" 6/24/25 – R6 was diagnosed with "Unspecified Psychosis Not Due To A Substance Or Known Physiological Condition" 8/20/25 – R6's Quarterly Minimum Data Set (MDS) documented "Active Diagnosis… Non-Alzheimer's Dementia… Anxiety Disorder, Depression…Psychotic Disorder" 7/11/25 9:19 PM – A psychiatry note by P3 (MD) documented "Patient seen for Initial Evaluation mood and medications management. Patient is very angry and delusional that people on the building killing Dogs. Patient is argumentive (sic) and threatening towards staff. Patient is alert and oriented self but confused about time and place… A/P (Assessment/Plan) Dementia Alzheimer's Type Late Onset. Mood Disorder. Patient will benefit with Depakote 125mg PO (by mouth) TID (three times a day) for Mood and Will follow up for mood and medications." 11/20/25 – R6's Quarterly MDS documented that R6 had	F0644	Continued from page 2 that all newly hired Social Worker Directors and MDS Coordinators demonstrate competency in identifying, referring, and coordinating care for residents requiring a Level II PASRR evaluation. Completion of this education is documented upon hire, and competency is validated through return demonstration and ongoing performance monitoring. D. The facility will utilize an audit sample that includes residents identified as having a new or significant change in diagnosis that may trigger the need for a Level II PASRR evaluation. This includes, but is not limited to new psychiatric diagnoses, behavioral symptoms, or related conditions. Where feasible, the audit sample will reflect approximately 10% of the facility's daily census and will include residents from the following categories: new admissions, significant change MDS assessments, and residents with newly identified mental health or behavioral concerns. Audits will be conducted on an ongoing for a period exceeding one month to ensure sustained compliance. The audit schedule will consist of weekly audits for four (4) weeks, followed by monthly audits until 100 % compliance is achieved for three (3) months and quarterly audits thereafter through the QAPI program. Any concerns identified during the audit process will result in immediate corrective action	

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F0644 SS = D	Continued from page 3 "Non-Alzheimer's Dementia, Anxiety Disorder, Depression and Psychotic Disorder." In addition, R6 received antipsychotics on a routine basis, 2/17/26 R6's Significant change MDS documented that R6 had Non-Alzheimer's Dementia, Anxiety Disorder and Psychotic Disorder. R6 continued to receive antipsychotics on a routine basis. 3/10/26 3:23 PM – A review of R6's clinical record lacked evidence of an updated PASRR evaluation when R6 was diagnosed with anxiety and psychotic disorders after her admission to the facility on 2/4/25. 3/12/26 2:22 PM - In an interview, E4 (SW) confirmed that he did not request an updated PASSR evaluation to the State PASRR authority. 3/13/26 at 1:00 PM- Finding was reviewed with E1 (NHA) and E3 (ADON) during the exit conference.	F0644		